How much did your health plan pay?

How much do you owe?

Here's how to find out!

BlueCross BlueShield of South Carolina

www.SouthCarolinaBlues.com

Understanding Your State Health Plan Explanation of Benefits (EOB)

Your Explanation of Benefits, or EOB, is a form we send you that gives you details about your claim status. It features important information about services you received, how much we covered, how much you may owe your provider and much, much more.

You'll notice we've gathered most of the quick details you're looking for into a convenient Summary Information box. Details about your claims are in a column, so you can easily track the information about each service you received. We've also included helpful definitions, so you'll know more about what you're reading!

This convenient guide will walk you through a typical EOB. Thank you for allowing us to serve you!

EXPLANATION OF BENEFITS (EOB)

1234

(ADDRESS)

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

(1) If you have a question about your claim, please call Customer Service at 1-800-868-2520 OR LOCALLY AT 736-1576 MON. - FRI. 8:30 A.M. - 4:30 P.M.

(DATE)

JOHN DOE
PO BOX 0000
ANYWHERE, SC 12345

(2) **SUMMARY INFORMATION** (3) CHECK NO.: 123456789

(4) Patient's Name	(5) Relationship to Policyholder	(6) ID No.	(7) Claim No.
JONATHAN DOE	CHILD	123456789	123456789-99-99

(8) TOTAL CHARGE FOR YOUR CLAIM:	(9) TOTAL AMOUNT WE PAID:	(10) WHAT YOU OWE PROVIDER:
870.85	522.51	130.63
		The provider can bill you for this amount if you have not yet paid.

(11) To date, you have satisfied 250.00 of the 250.00 deductible for the benefit period that began 01/01/2006. This claim contributed 130.63 toward your out-of-pocket maximum. You have satisfied 1,072.04 of the 2,000.00 out-of-pocket maximum for this benefit period. We have paid a total of 4,555.54 for this person this benefit period.

DETAIL INFORMATION

(12) **Provider**	BC HOSPITAL	BC HOSPITAL	BC HOSPITAL	
(13) **Network Participation**	YES	YES	YES	
(14) **Dates of Service**	01/01/06	01/01/06	01/01/06	
(15) **Type of Service**	OUTPT RADIOLOGY	OUTPT LAB/PATH	OUTPATIENT HOSPITAL	
(16) **Charge**	89.00	123.87	657.98	
(17) **Amount Not Covered**	22.24 01*	30.97 01*	164.50 01*	
(18) **Covered Expenses**	66.76	92.90	493.48	
(19) **Deductible**	.00	.00	.00	
(20) **Copayment**	.00	.00	.00	
(21) **Allowed Amount**	66.76	92.90	493.48	
(22) **Coinsurance**	13.35	18.58	98.70	
(23) **Amount Paid**	53.41	74.32	394.78	

(24) *Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

PAGE 001 **www.SouthCarolinaBlues.com**

(25) **Helpful Definitions** (Please check your schedule of benefits in your benefit booklet for details.)

Amount Approved for Coordination — the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period — the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance — the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment — a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible — the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation — the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation — this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES," this is a network participant. If "NO," this is not a network participant. If "N/A," the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket Maximum — the highest amount of covered expenses you will have to pay during a benefit period.

Total Benefit Allowed — the amount we would have paid if another insurance carrier was not involved.

(26) **APPEAL OR REVIEW**

(APPEALS INFORMATION)

(27) **Remarks Section**

01 THIS AMOUNT REPRESENTS THE DIFFERENCE BETWEEN THE ACTUAL CHARGE AND THE PRE-NEGOTIATED REIMBURSEMENT AMOUNT. YOU ARE NOT RESPONSIBLE FOR THESE NON-COVERED CHARGES.

Route Code: B2N
Group Number: 123456789

1. **Customer Service Information:** If you* have any questions about your coverage or the information provided, please call BlueCross BlueShield.
2. **Summary Information:** In this section, you'll find important information about the Plan.
3. **Check Number:** This is the number of your reimbursement check. It helps us track the check in case you have any questions about payments. If we don't make a payment, no check number will be listed.
4. **Patient's Name:** This is the name of the person who received the services.
5. **Relationship to Policyholder:** This shows how the person receiving services is related to the policyholder; i.e. child, husband, wife, etc.
6. **ID Number:** This is the policyholder's number. You must have this number when calling BlueCross BlueShield.
7. **Claim Number:** This is the number assigned to your claim for tracking purposes.
8. **Total Charge for Your Claim:** This is the total amount that the provider charged (sum of amount/s in Line 16).
9. **Total Amount We Paid:** This is the total reimbursement we paid to the provider or to you. Reimbursement is based on a variety of factors, such as coinsurance and amounts covered and not covered, and the type of coverage you have (sum of amount/s in Line 23).
10. **What You Owe Provider:** This is what you pay (sum of amount/s in Lines 19, 20, and 22).
11. **Deductible and Out-of-Pocket Summary:** This explains the following: 1) how much you have paid toward your deductible, if any; 2) how much of the current claim went toward your maximum out-of-pocket expenses; 3) how much you have paid toward your out-of-pocket maximum in the current benefit period; and 4) how much we have paid in benefits during the benefit period for the patient receiving services.
12. **Provider:** This is the healthcare professional (doctor, surgeon, etc.) or facility which provided services to the patient.
13. **Network Participation:** This shows whether the provider you visited participates in our network. Typically, we reimburse less to out-of-network providers than we do to those who are network members.
14. **Dates of Services:** This shows when the services were provided.
15. **Type of Service:** This describes the services that were provided for each claim.
16. **Charge:** This is the total amount charged by the provider for services received by the patient.
17. **Amount Not Covered:** These are costs for services that are not covered under the Plan or costs that are higher than the maximum allowed for services.
18. **Covered Expenses:** This is the amount eligible for reimbursement after non-covered or higher-than-allowable costs have been subtracted. The portion of this amount that will be reimbursed is calculated based on the Plan.
19. **Deductible:** This is the amount, if any, that you pay to providers for services each benefit period before the Plan begins to pay. You do not send this amount to us. We subtract the deductible amount from covered expenses on the claim you and the providers send to us.
20. **Copayment:** This is the non-reimbursable fee, established by the Standard Plan, that you pay each time you receive a service. The Savings Plan does not have copayments or pre-occurrence deductibles.
21. **Allowed Amount:** This is the portion of your total charge that will be used to determine how much you will pay in coinsurance. The allowable amount is the maximum the Plan will pay for a covered service.
22. **Coinsurance:** This is the percentage of the allowable amount of covered expenses you pay. For example, if the Plan pays 80 percent of the allowable amount, the remaining 20 percent – which is what you would pay – is your coinsurance.
23. **Amount Paid:** This is what we paid, based on your coverage.
24. **Remarks Note:** This directs you to information that is further explained in the Remarks Section (#27).
25. **Helpful Definitions:** This defines key terms to help you better understand the explanation of benefits.
26. **Appeal or Review Information:** This explains how to file an appeal if you disagree with our decisions regarding payment.
27. **Remarks Section:** This section provides explanations related to the Amount Not Covered (Line 17).

* **You:** This is defined as any person who is insured under the policy, i.e. you and/or your covered dependents.